U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 21 May 2004

CASE No.: 2003-BLA-5986

In the Matter of:

DONALD E. GILBERT,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Timothy F. Cogan, Esquire
For Claimant

William S. Mattingly, Esquire
For Employer

BEFORE: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER- DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq* (the Act). Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Regulations.

The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

The Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a formal hearing on June 3, 2003.[1] DX 49. A hearing was held before me on November 18, 2003 in Weirton, West Virginia (see "Background and Procedural History", *infra,* for a complete account of the procedural history of this case).[2]

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

ISSUES

The following issues remain contested:

(1) Whether Claimant has pneumoconiosis as defined by the Act and Regulations;
(2) Whether his pneumoconiosis arose out of coal mine employment;
(3) Whether Claimant has a totally disabling respiratory impairment; and
(4) Whether his total disability is due to pneumoconiosis. TR 17.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History[3]

Claimant Donald E. Gilbert filed his claim for benefits on February 1, 2001. DX 2. On March 10, 2003, the claims examiner issued a Proposed Decision and Order Awarding Benefits. DX 42. Employer disagreed with the determination and requested a formal hearing. DX 43.

At the hearing, Claimant testified that he was exposed to asbestos in addition to coal mine dust. TR 18. Claimant was told by mechanics that the motors he worked near contained asbestos. TR 19. He was told that all of the windings in the motors were made of asbestos. *Id*.

---

[1] The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit, and EX for Employer's exhibit.

[2] At the hearing, Director's exhibits 1–51, Claimant's exhibit 1, and Employer's exhibits 2–4 and 6 were admitted into evidence. TR 6–14. I reserved judgment on Employer's exhibit 1, the deposition of Dr. Altmeyer. By letter dated December 3, 2003, Employer advised that the treatment notes and deposition testimony of Dr. Altmeyer were not part of its affirmative evidence. For reasons outlined in an Order dated January 26, 2004, I decided to exclude the deposition testimony of Dr. Altmeyer. On December 17, 2003, Employer filed the deposition transcript of Dr. Rosenberg that was taken on November 17, 2003. That exhibit is marked Employer's exhibit 5 and is hereby admitted into evidence. Also, on February 23, 2004, the parties filed a Joint Stipulation of Medical Evidence. On January 21, 2004, Employer filed its closing brief and on January 15, 2004, Claimant filed his closing brief.

[3] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (*i.e.* March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because Claimant's last exposure to coal mine dust occurred in West Virginia, this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

When Claimant sat in the cab of the locomotive, he breathed air that came off the motors. *Id*. He was exposed to asbestos in this manner for twenty to twenty-five years. TR 20. He noted that other sources of asbestos in the coal mine included arc shields and flame retardant blankets near the face. TR 20–24. Claimant stated that he worked for a short period of time as a foreman for an insulation company. One of the jobs during this period was insulating/sound-proofing a high rise boiler room with a blown asbestos mixture. TR 25. Claimant stated he weighed 260 pounds and that he had been told by Dr. Altmeyer he could no longer work due to damage to his lungs caused by asbestosis and, to a lesser extent, black lung. *Id*. Claimant's last job, in 1999, was as a motor man. TR 26. He ran the end loader, loaded trucks, and stockpiled coal. *Id*. The heaviest thing he had to lift was about fifty pounds but in a derailment he would have to lay rail, carry tires, shovel, and use a pick. TR 27. Claimant was on oxygen for any physical activity requiring exertion. TR 28. Claimant testified he had been awarded state benefits for a 50% disability due to black lung. *Id*. He stated that the examination with Dr. Fino took only five to ten minutes and that Dr. Fino never listened to his lungs with a stethoscope. *Id*. Claimant was on oxygen at the time of his examination with Dr. Fino but could not remember if he had a conversation with Dr. Fino about the oxygen. TR 29.

On cross-examination, Claimant stated he smoked about one pack of cigarettes per day for about twenty years and that he quit smoking 20–25 years ago. TR 30. Claimant added he had been on oxygen since 1999 and that Dr. Altmeyer had prescribed the oxygen for him. Claimant stated that he still sees Dr. Altmeyer every three to six months. *Id*. He also sees Dr. Friend, a cardiologist, every six months to a year for plaque buildup. TR 31. Claimant stated that he had the conversation with the mechanic about the asbestos in the motors in the 1980s and that the motors he worked with subsequent to that time were identical. He added that he had no other independent knowledge that there was actually asbestos in the motors. TR 34. Claimant admitted he put on about thirty pounds in the last four to five years. TR 37. It was suggested to Claimant that he may have sleep apnea. TR 38. Claimant used his oxygen when he needed to walk and had it on at the hearing. TR 39. Claimant spent nearly thirty years in underground coal mining. TR 40. Claimant stated that he could not do his last job as motorman because of his breathing and that he would be unable to do any walking required by the job. TR 41. He also could not carry a fifty- or 100-pound bag of sand the distance required by his job. TR 42.

Medical Evidence

Chest X-rays[4]

Exhibit Number	Date of X-ray	Physician/ Qualifications	Diagnosis
DX 26	11-12-90	Levesque (Wheeling Hosp.)	Negative
DX 26	1-13-92	Slaysman (Wheeling Hosp.)	Chronic interstitial changes with no acute process or interval change from prior study
DX 26	1-5-94	Bonnesen (Wheeling Hosp.)	Slight interstitial fibrotic change but no active inflammatory disease

[4] Shaded areas indicate multiple readings of one x-ray.

DX 26	6-5-96	Stake (Wheeling Hosp.)	Minimal bibasilar interstitial scarring w/no change from 1-5-94
DX 26	6-22-96	Neis (Wheeling Hosp.)	No acute active pulmonary disease
DX 26	6-27-96	Slaysman (Wheeling Hosp.)	Bilateral atelectasis and slight perihilar infiltrate
DX 26	6-28-96	Slaysman (Wheeling Hosp.)	Minimal atelectatic change and possibly some slight residual perihilar infiltrate
DX 26	7-1-96	Defilippo (Wheeling Hosp.)	Minimal plate-like atelectasis in left base, mild air space disease in left lower lobe, upper zones clear, right lower lobe atelectasis partially resolved
DX 26	4-24-98	Stake (Wheeling Hosp.)	Status post thoracic surgery; lung fields clear w/no evidence of acute infiltrate
DX 26	4-30-98	Slaysman (Wheeling Hosp.)	No active cardiopulmonary process
CX 1	7-19-99	Saludes (East Ohio Regional Hosp.)	1/0, s/t and bilateral pleural thickening
DX 26	10-14-99	Slaysman (Wheeling Hosp.)	Mild diffuse chronic interstitial changes, no change from 4-30-98
DX 24	10-14-99	Altmeyer/B	1/0, s/t, both mid and lower lung zones; mild bilateral pleural thickening
EX 6	10-14-99	Wiot/ BCR,B	Negative for CWP, previous CABG
DX 24	3-13-00	Altmeyer/B	Unchanged w/some interstitial changes consistent w/asbestosis as well as some pleural thickening bilaterally
DX 26	3-13-00	Flynn (Wheeling Hosp.)	Mild left basilar scarring w/no significant interval changes from 10-14-99
EX 6	3-13-00	Wiot/ BCR,B	Negative for CWP, previous CABG
DX 24	9-13-00	Altmeyer/ B	Interstitial lung disease and pleural thickening are the same
DX 24	9-13-00	Benson (Wheeling Hosp.)	Chronic appearing interstitial changes throughout both lungs, no significant change from 3-13-00
EX 6	9-13-00	Wiot/ BCR,B	Negative for CWP, previous CABG
DX 26	11-10-00	Loh (Wheeling Hosp.)	Mild cardiomegaly w/flattening of diaphragm suggesting some emphysema, no acute infiltrates or significant change since 9-13-00
DX 26	11-12-00	Caruso (Wheeling Hosp.)	Unchanged mild cardiomegaly
DX 26	3-13-01	Slaysman (Wheeling Hosp.)	Slight cardiomegaly, chronic interstitial changes unchanged
DX 24	3-13-01	Altmeyer/ B	Interstitial changes remain unchanged
EX 6	3-13-01	Wiot/ BCR, B	Negative for CWP, previous CABG
DX 26	9-2-01	Balzano (Wheeling Hosp.l)	Trace bilateral effusions w/minimal fluid in minor fissure, probable cardiomegaly
DX 26	9-13-01	Benson (Wheeling Hosp.)	No significant change from 3-13-00; chronic interstitial changes both lungs; borderline cardiomegaly
DX 26	10-29-01	Stake (Wheeling Hosp.)	Cardiomegaly; mild bibasilar interstitial scarring w/bilateral pleural thickening
DX 24	10-29-01	Altmeyer/ B	Chest x-ray is about the same

EX 6	10-29-01	Wiot/ BCR,B	Negative for CWP; co; previous CABG
DX 24	3-6-02	Benson (Wheeling Hosp.)	Cardiomegaly unchanged from 10-29-01; chronic interstitial changes are present diffusely throughout both lungs, unchanged from 10-29-01
DX 24	3-6-02	Altmeyer/ B	Chronic interstitial changes, bilateral pleural thickening, cardiomegaly and evidence of prior cardiac surgery; unchanged from prior x-rays
DX 22	3-6-02	Wiot/ BCR,B	Negative for CWP; co; previous CABG
DX 20, 19	5-10-02	Noble/ BCR,B	1/0, s/p, 6 zones; mild cardiomegaly
DX 21	5-10-02	Gaziano/ B	Ca; enlarged heart; underexposed
DX 23	5-30-02	Fino/ B	0/0

Pulmonary Function Studies[5]

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify?
CX 1	7-19-99	58	------	3.15	------	3.76	No
DX 24	11-1-99	58	70"	2.94	------	3.48	No
DX 18	5-10-02	61	72"	2.62	77	2.96	No
DX 23	5-30-02	61	71.5"	2.55	91	2.79	No

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify?
CX 1	7-19-99	54.2	33.5	Yes
DX 24	9-16-99	66.6	34.6	No
DX 15[6]	5-10-02	59.2	39.5	Yes
DX 23	5-30-02	52	39	Yes

Medical Reports

Dr. Melvin T. Saludes

The medical evaluation of Dr. Saludes is dated July 19, 1999 and appears at CX 1. The qualifications of Dr. Saludes are unknown. Dr. Saludes conducted a black lung evaluation of Claimant at the East Ohio Regional Hospital. He noted that Claimant had been short of breath for about one year and would become breathless climbing one flight of steps. Claimant also complained of a daily non-productive cough for about one year and noted symptoms consistent with paroxysmal nocturnal dyspnea. Claimant's past medical history included myocardial infarction, coronary bypass graft in 1996, and diabetes mellitus. Claimant smoked one to two packs of cigarettes per day for twenty years but Claimant quit smoking over twenty years ago.

[5] Due to discrepancies in height, I base qualification of the vent studies on an average height of 71.17 inches.

[6] Dr. Gaziano validated this arterial blood gas as being acceptable. DX 16.

Dr. Saludes reviewed Claimant's occupational history, noting that for the past twenty years Claimant worked as a motor man. Physical examination of the chest revealed diminished breath sounds and diminished air exchange with no rales or wheezes. An EKG showed left atrial abnormality with anterolateral ischemic changes. Pulmonary functions studies showed no restriction but a mild reduction in diffusing capacity; arterial blood gases revealed a mild to moderate hypoxemia at rest with metabolic acidosis and respiratory alkalosis. The chest x-ray was read as 1/0, s/t with bilateral pleural thickening. Dr. Saludes concluded Claimant had "evidence of black lung disease in the range of 10–20%." The physician concluded Claimant also had evidence of asbestos-related lung disease with pleural thickening.

Dr. Attila Lenkey

The medical report of Dr. Lenkey is dated August 2, 2002 and appears at DX 14. Dr. Lenkey examined Claimant at the request of the Department of Labor on May 23, 2002. Dr. Lenkey reviewed Claimant's occupational history and noted a family history positive for heart disease and emphysema. Claimant reported a medical history of pneumonia, pleurisy, arthritis, heart disease, allergies, and diabetes mellitus. Dr. Lenkey noted a smoking history of one to two packs per day from ages 19–44. Claimant's chief complaints were wheezing, dyspnea, cough, chest pain, ankle edema, and paroxysmal nocturnal dyspnea. On physical examination, Claimant was noted to be obese, weighing 266 pounds. The remainder of the examination was unremarkable. A chest x-ray was read as 1/0, s/p and a vent study was borderline OAD. Dr. Lenkey diagnosed Claimant as having coal workers' pneumoconiosis (CWP) due to coal dust exposure. Dr. Lenkey concluded Claimant was 100% impaired by CWP, noting Claimant would not be able to perform duties in the mines based on his current findings.

The deposition of Dr. Lenkey was taken on November 11, 2002 and appears at DX 27. Dr. Lenkey testified that he is Board-Certified in Internal Medicine, Pulmonary Disease, and Sleep Medicine. He had been practicing since 1993. He noted that 80% of his patients were pulmonary and that a fair number of his patients were coal miners. He was unsure of Claimant's last position in the mines but noted that mine jobs required mild to moderate levels of exertion due to walking, carrying, and lifting. Dr. Lenkey noted Claimant had a fifty-pack-year history of smoking, which he classified as moderate but significant. Dr. Lenkey did not diagnose bronchitis. Based on a body mass index, Dr. Lenkey opined Claimant would be in the mild to moderate obese range. He noted that Claimant's obesity could be contributing to Claimant's shortness of breath. He added that Dr. Noble, a B-reader, read Claimant's chest x-ray as 1/0. Dr. Lenkey noted that there was not always an agreement between the x-ray findings and the physiologic impairment. Dr. Lenkey interpreted the pulmonary function study as showing borderline obstructive airways disease and that a borderline restrictive impairment may be present but that full lung volumes needed to be done to confirm. Dr. Lenkey agreed that a series of pulmonary function studies conducted over a period of years could be helpful in differentiating the different lung processes. Dr. Lenkey based his opinion on his one-time examination of Claimant and the correlating diagnostic testing. He thought that the reason the oxygen level was low was because of Claimant's underlying occupational lung disease and that Claimant could have a heart condition that he did not know about. He opined that the contribution of Claimant's obesity to the hypoxemia was "probably slight, if any." He then stated that Claimant's obesity "probably had a mild effect on his oxygen tensions." Dr. Lenkey

based his diagnosis of CWP on the number of years of coal mine dust exposure, abnormal pulmonary function testing, and the abnormal chest x-ray. He noted that Claimant worked thirty years underground as a bolter and rock duster and that those were some of the dirtiest jobs. He based his opinion of 100% impairment on the hypoxemia from the blood gases, the pulmonary function test, abnormal chest x-ray, and symptoms. He could not render an opinion whether any portion of Claimant's impairment was due to heart disease. Dr. Lenkey agreed that Claimant's cigarette smoking also contributed to his lung impairment and estimated that cigarette smoking contributed to 50% of his impairment. Dr. Lenkey stated that Claimant would still have an impairment had he never smoked cigarettes but it would not be as much. Dr. Lenkey noted that he did not see any evidence of asbestosis.

Dr. Gregory Fino

The medical report of Dr. Fino is dated June 3, 2002 and appears at DX 23. Dr. Fino is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Fino examined Claimant on May 30, 2002. He reviewed Claimant's medications and noted an occupational history of thirty years of underground coal mine employment that ended in 2000. Claimant's last job was as a motor man, which required some heavy labor. Claimant also reported exposure to asbestos through a motor and through working in buildings with asbestos exterior siding. Dr. Fino noted a history of shortness of breath for ten years that was getting progressively worse. Claimant stated that the shortness of breath did not interfere with his daily activities. He added that dyspnea occurred when walking uphill, lifting and carrying, and when performing manual labor. Claimant also admitted to daily cough and mucus. Dr. Fino noted Claimant's past medical history and noted a family history of lung disease and heart disease. Physical examination was unremarkable. A chest x-ray was read by Dr. Fino as 0/0, a vent study showed poor effort, lung volumes were slightly reduced consistent with obesity, and arterial blood gases showed moderate hypoxemia. Dr. Fino then reviewed and summarized various medical records.

Dr. Fino diagnosed Claimant as having a normal pulmonary examination and obesity-related decrease in lung volumes. He noted that Claimant experienced a 10% increase in weight between 2000 and 2003 and that this affected his pulmonary capacity. Dr. Fino stated that the area of abnormality was in Claimant's lung volumes and that the pattern exhibited by Claimant was a classic finding for obesity. Dr. Fino also opined that obesity was the cause of Claimant's hypoxemia. He noted that Claimant had fairly mild resting hypoxemia in 1982, 1999, and 2000 but that during Dr. Fino's examination, Claimant's hypoxemia became moderate. He added that this drop in pO2 was consistent with obesity, which is a known cause of hypoxemia. Dr. Fino opined this hypoxemia was not due to lung destruction or an impairment of oxygen transfer due to any lung disease. He based this conclusion on Claimant's normal diffusing capacity after correcting for effort. Dr. Fino stated that Claimant's obesity had a secondary impact on his lungs resulting in moderate hypoxemia. He noted that obesity caused a pushing up on the diaphragms and restricted the chest wall from moving. Dr. Fino concluded Claimant would be unable to return to his last coal mining job due to moderate hypoxemia and his significant history of coronary artery disease (CAD). Dr. Fino opined there was no evidence of impairment due to any intrinsic lung disease. In conclusion, Dr. Fino opined there was insufficient objective medical evidence to justify a diagnosis of CWP, that Claimant was disabled due to the secondary effects of obesity and CAD, and that coal mine dust played no role any impairment or disability.

The deposition of Dr. Fino was taken on November 12, 2003 and appears at EX 4. Dr. Fino stated that none of Claimant's medications were for the treatment of a lung disorder. Dr. Fino noted that Claimant's hypoxemia was due to his obesity and agreed that sleep apnea could contribute to the hypoxemia. He opined Claimant's remote smoking history did not affect his lungs based on the fact Claimant had no evidence of obstructive lung disease. He admitted that some of Claimant's symptoms could be due to heart disease. However, Dr. Fino noted that all of Claimant's symptoms could be explained by his obesity. He stated that Claimant was at least seventy pounds overweight and 30% over his ideal body weight. He added that Claimant had put on thirty pounds in the last two years. Dr. Fino noted that the chest x-ray showed generalized haziness in the lower portion of both lung fields but did not note it in his report because it was not due to pneumoconiosis. He concluded Claimant's lung tissue was normal based on the chest x-ray, normal diffusing capacity, pattern of abnormalities of lung volumes, and a weight gain of thirty pounds in two years, all consistent with an extrinsic problem. Dr. Fino explained that lung destruction due to CWP would be manifested by either over-inflated lung volumes or under-inflated lung volumes, which Claimant did not have. Therefore, the abnormal blood gases were not a result of lung destruction. With regards to the 5-10-02 pulmonary function study, he agreed that it showed a restrictive type abnormality but that it was again due to Claimant's obesity. He noted that the only way the restriction could be due to pneumoconiosis was by the presence of fibrosis.

Dr. Mohommed Ranavaya

The medical report of Dr. Ranavaya is dated December 16, 2002 and appears at DX 28. Dr. Ranavaya is Board-Certified in Occupational Medicine. He conducted a medical record review at the request of Claimant. Dr. Ranavaya noted Claimant had a history of coal mine dust exposure for thirty years. He noted Claimant "reportedly" had radiographic evidence of CWP. Therefore, he opined it was medically reasonable to conclude Claimant had CWP due to his occupational exposure to dust. Dr. Ranavaya stated that the pulmonary function test performed on May 10, 2002 showed moderately severe disabling pulmonary impairment as reflected by moderately severe hypoxemia observed on arterial blood gases at rest. He opined this amount of pulmonary impairment would prevent Claimant from performing his last coal mine employment. He added it was medically reasonable to conclude Claimant had CWP "most likely" due to his occupational exposure to dust in the coal mine industry and that he had a moderately severe disabling pulmonary insufficiency that primarily arose from his coal mine dust exposure.

Dr. David M. Rosenberg

The medical report of Dr. Rosenberg is dated September 16, 2003 and appears at EX 2. Dr. Rosenberg is Board-Certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine and is a B-reader of chest x-rays. EX 3. He conducted a medical record review at the request of Employer. Dr. Rosenberg stated Claimant had worked in the coal mines for twenty-five years and had been a non-smoker throughout his life. In general, he noted, the pulmonary function studies showed normal lung volumes, without evidence of restriction or airflow obstruction, with preserved ventilation. He added that at times Claimant's diffusing capacity was mildly reduced and that he had demonstrated hypoxemia to a disabling level. Dr. Rosenberg noted that the x-rays were either negative or with a degree of linear opacities. He concluded that

when all of the evidence was looked at in total, the information supported Claimant as having an interstitial form of lung disease. However, it did not represent CWP. He explained that the linear pattern and lower lung field distribution was that of idiopathic pulmonary fibrosis or even asbestosis. Dr. Rosenberg concluded Claimant did not have CWP or associated impairment. He added that while Claimant had a disabling respiratory state, this was not related, caused or hastened by past inhalation of coal mine dust. He opined Claimant had some form of interstitial lung disease of a linear character, such as asbestosis or idiopathic pulmonary fibrosis.

The deposition of Dr. Rosenberg was taken on November 17, 2003 and appears at EX 5. Prior to the deposition, Dr. Rosenberg reviewed the medical reports of Drs. Fino, Ranavaya, and Lenkey. [7] Dr. Rosenberg noted that the 5-10-02 pulmonary function study showed a mild degree of restriction with no obstruction. Dr. Rosenberg stated that a thirty-pound increase in weight and corresponding increase in body mass index probably caused and was responsible for the increase in restrictive numbers. He characterized Claimant as having massive obesity based on a body mass index of about thirty-eight at the time of his evaluation with Dr. Lenkey. Dr. Rosenberg noted that massive obesity could cause hypoventilation, obstruction in the outer airways, and/or a ventilation profusion mismatch leading to hypoxemia. He explained that hypoxemia could cause an increased spasm of blood vessels within the lung, causing pulmonary hypertension, and that the hypoxemia could lead to worsening left-sided heart failure. Dr. Rosenberg agreed that Claimant would be unable to perform his last coal mine employment based on the degree of gas exchange abnormality. He opined that the major contributing factors to the abnormality were obesity, hypoventilation, ventilation profusion, and mismatched obesity. He added that Claimant also had linear interstitial lung disease and some heart failure. He concluded Claimant did not have any coal mine induced lung disease. He noted Claimant did not have roetenographic evidence of CWP. He added obesity was Claimant's major problem and that coal dust exposure would not hasten his underlying medical conditions. Prior to the deposition, Dr. Rosenberg reviewed various x-ray films from 1999 through 2002 and noted that the degree of interstitial change was variable from 0/0 to 1/1. He added that he was not convinced 100% that this was asbestosis or idiopathic pulmonary fibrosis. He stated that there were absolutely no changes consistent with CWP. Dr. Rosenberg concluded Claimant's obesity hyperventilation syndrome could explain his entire respiratory status. On cross-examination, Dr. Rosenberg stated that a diagnosis of idiopathic pulmonary fibrosis was unlikely because the x-ray films did not follow the progressive pattern one would expect to find if it was truly IPF. He made this conclusion after reviewing the chest x-rays prior to the deposition.

Miscellaneous Medical Records

Dr. Robert B. Altmeyer

The treatment records of Dr. Altmeyer from September 16, 1999 through April 3, 2002 appear at DX 24. Dr. Altmeyer is Board-Certified in Internal Medicine, Pulmonary Disease, Critical Care Medicine, and Geriatric Medicine. The first office note is dated October 14, 1999.

[7] Dr. Rosenberg was also given the deposition transcript of Dr. Altmeyer to review. Since the deposition transcript of Dr. Altmeyer was excluded from being admitted into evidence, any reference to Dr. Altmeyer's deposition will not be considered evidence in this matter.

He noted Claimant was referred to him for evaluation of hypoxemia and asbestosis. He added that prior to 1969, Claimant worked for a company where he blew an asbestos-containing compound onto the walls and ceilings with an air gun. Claimant reportedly inhaled a significant amount of asbestos prior to 1969. Claimant started working in the coal mine in 1969. Claimant complained of a mild cough and shortness of breath on exertion. He noted a smoking history of one to two years and that Claimant quit smoking twenty years ago. Physical examination revealed prominent crackles at the lung bases. The chest x-ray was read as 1/0, s/t in both mid and lower lung zones with mild bilateral thickening. He opined Claimant had pulmonary asbestosis based on typical crackles at the bases, pleural thickening, mild hypoxemia, and significant exposure to asbestos with an appropriate latency period. He opined that Claimant's obesity and asbestosis were contributing significantly to his mild hypoxemia. After receiving the results of a pulmonary function study, Dr. Altmeyer noted that there was no airflow obstruction.

The next report is dated February 1, 2000. He noted Claimant's diffusing capacity had dropped since 11-1-99 and that he was slightly more short of breath. Claimant had gained an additional five pounds. Physical examination revealed the same fine, velcro crackles at the bases. He advised Claimant to repeat the diffusing capacity in two months and return for an evaluation at that time.

In a note dated March 13, 2000, Dr. Altmeyer stated that Claimant's chest x-ray was the same with some interstitial changes consistent with asbestosis as well as some pleural thickening bilaterally. He noted that the diffusing capacity was normal and had reverted to its prior level. Claimant's weight was noted to be 221 pounds. Claimant was advised to return in six months with a chest x-ray and diffusing capacity.

On September 13, 2000, Claimant was again evaluated by Dr. Altmeyer. His chest x-ray and diffusing capacity remained the same. Claimant's weight had increased to 249 pounds and he was noted to be very obese. On physical examination, Claimant had a few crackles at the lung bases and was advised to return in six months.

The next report was dated March 13, 2001. Dr. Altmeyer noted Claimant's chest x-ray was the same and that he had a slight but not statistically significant drop in is diffusing capacity. He added, "As you know, he is a former insulation worker and was exposed to asbestos many years ago." Claimant continued to have the same Velcro crackles at the bases. He advised Claimant to continue his oxygen and return in six months.

Dr. Altmeyer saw Claimant again on October 29, 2001. The chest x-ray and diffusing capacity were the same. Claimant's weight had increased to 266 pounds. He had crackles at the lung bases but no signs of congestive heart failure. Claimant was told to return in six months.

A sleep study was performed on February 18, 2002 and the results were part of Dr. Altmeyer's file. Claimant was diagnosed as having a disorder of excessive somnolence associated with sleep induced respiratory impairment, and sleep apnea DOES syndrome.

The next report by Dr. Altmeyer is dated March 11, 2002. He noted that Claimant had a significant degree of asbestosis as well as obesity, which increase his risk for having any type of

surgery with general anesthesia. It was noted that Claimant also suffered from coronary artery disease. Claimant's weight was noted to be 266 pounds and he had a few crackles at the base of the lungs. Claimant's chest x-ray was noted to be the same.

The last medical report by Dr. Altmeyer is dated April 3, 2002. Dr. Altmeyer noted Claimant's diffusing capacity was normal and that Claimant was feeling well. He added Claimant was not having any particular breathing problems. He stated Claimant had excessive daytime hypersomnolence from sleep apnea syndrome. He recommended that Claimant speak to his primary care physician about a referral to an ENT doctor to see if surgery could be beneficial. Claimant's weight was noted to be 266 pounds and his chest was clear with no wheezes and no crackles. Dr. Altmeyer noted Claimant had a history of asbestosis.

Wheeling Hospital

The medical records from Wheeling Hospital from November 12, 1990 through April 3, 2002 appear at DX 26. The record consisted primarily of chest x-ray reports that have already been summarized above.

State Compensation Award

On February 25, 2002, the Workers' Compensation Division of the State of West Virginia issued a letter advising Claimant that on 2-21-02 an administrative law judge awarded Claimant a 45% additional permanent partial disability. DX 10.

Conclusions of Law

Length of Coal Mine Employment

The parties stipulated and I find the evidence of record supports a finding that Claimant was a coal miner, within the meaning of the Act, for at least 30 years. TR 17 .

Date of Filing

I find that Claimant filed this claim for benefits on February 1, 2002. DX 2.

Responsible Operator

The parties stipulated and I find the evidence of record supports the conclusion that Consolidation Coal Company is the properly named responsible operator in this case. TR 17.

Dependents

I find that Claimant has one dependent, his wife Patricia, for purposes of augmentation of benefits under the Act. TR 17.

Entitlement: Determination of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [8] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[9] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

This broad definition of pneumoconiosis "effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines." *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68, 2-78 (4th Cir. 1990), 914 F.2d 35 (4th Cir. 1990), *citing Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

A claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or

---

[8] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358, 1364 (4th Cir. 1996); *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–15 (3d Cir. 1995).

[9] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
  (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
  (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit Court of Appeals held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis.

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990), *citing Edmiston v. F & R Coal,* 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence he or she deems to be most probative, even if it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit noted that pneumoconiosis is "progressive and irreversible" such that it is proper to accord greater weight to later positive x-ray studies over earlier negative studies. It stated further that generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition. *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 137 F.3d 799 (4th Cir. 1998).

In summary, there are thirty-six interpretations of twenty-three x-rays in the record. The Benefits Review Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999). Many of the interpretations were done by radiologists at Wheeling Hospital. The qualifications of these physicians are not part of the record and therefore will be accorded less weight. There were, however, seven readings by dually qualified Board-certified radiologists and B-readers. Of the seven, six were read as negative for pneumoconiosis and one was read as positive for pneumoconiosis. Accordingly, as the majority of the more credible interpretations are negative for pneumoconiosis, I find that Claimant has not established, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Biopsy Evidence

Pursuant to § 718.202(a)(2), Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, pneumoconiosis has not been established in this manner.

The Presumptions

Under § 718.202(a)(3), a miner is presumed to be suffering from pneumoconiosis if the presumptions provided in §§ 718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the § 718.306 presumption because he is still living. Moreover, Claimant is ineligible for the § 718.304 presumption because there is no credible evidence that he suffers from complicated pneumoconiosis.[10]

Based on the foregoing, Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(3).

Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such a conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion.

Smoking History

In general, in order for physicians to arrive at a proper, reasoned diagnosis, it is essential that they be presented with an accurate picture of a patient's complaints, prior medical history, working or environmental conditions, and social habits, including smoking. See *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986) (An opinion may be given less weight where the physician did not have a complete picture of the miner's condition.).

Specifically, in Black Lung cases, a claimant's smoking history is of particular importance. This is because the pulmonary manifestations of smoking are often similar to that of coal workers' pneumoconiosis.

[10] Complicated pneumoconiosis is established by x-rays classified as Category A, B, C, or by an autopsy or biopsy that yields evidence of massive lesions in the lung. I find that there are no x-rays in evidence that have been so classified. None of the physicians who rendered an opinion in this case diagnosed the presence of complicated pneumoconiosis. Accordingly, this presumption is not applicable.

Claimant consistently reported a smoking history of one to two packs of cigarettes per day for a period of twenty to twenty-five years, having quit about twenty years ago. TR 30; CX 1; DX 14. Based on these reported histories, I find Claimant had a smoking history of approximately twenty to fifty pack years, ending about twenty years ago.

Analysis of Medical Opinions

Of record are the opinions of Drs. Saludes, Lenkey, Ranavaya, Altmeyer, Fino and Rosenberg. In general, Drs. Saludes, Lenkey, and Renavaya diagnosed pneumoconiosis, Drs. Fino and Rosenberg found no pneumoconiosis to be present, and Dr. Altmeyer diagnosed Claimant as having asbestosis.

I first note that Drs. Lenkey, Ranavaya, Altmeyer, Fino, and Rosenberg are highly qualified physicians who have excellent credentials. Drs. Lenkey, Altmeyer, Fino, and Rosenberg are Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Ranavaya is Board-Certified in Occupational Diseases. Accordingly, I find Drs. Lenkey, Ranavaya, Altmeyer, Fino, and Rosenberg to be highly qualified to render an opinion in this matter. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Conversely, the qualifications of Dr. Saludes are not part of the record. Therefore, in weighing the opinion of Dr. Saludes with the highly qualified opinions of the other consultants to this matter, I accord the opinion of Dr. Saludes less weight.

In general, more weight may be accorded to the conclusions of a treating physician as he is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989).

Section 718.104(d) codifies the "treating physician rule" and provides the following list of factors in weighing the opinion of the miner's treating physician: (1) nature of the relationship, (2) duration of the relationship, (3) frequency of the treatment, and (4) extent of treatment. Based on the medical records of Dr. Altmeyer, he started treating Claimant on September 16, 1999. DX 24. Dr. Altmeyer saw Claimant on three occasions in 2000, twice in 2001, and twice in 2002. DX 24. Based on the medical record, it appears Dr. Altmeyer treated Claimant for his symptoms associated with a diagnosis of asbestosis and obesity. Dr. Altmeyer conducted physical examinations of the lungs and monitored Claimant's chest x-ray and diffusing capacity approximately every six months. Based on the foregoing, it is clear that Dr. Altmeyer had been Claimant's treating physician from 1999 through 2002 and that he treated Claimant for his respiratory condition. Therefore, I find that Dr. Altmeyer has demonstrated he was in a unique position to render an opinion in this matter.

However, I find that Dr. Altmeyer's opinion that Claimant had asbestosis does not fall within the meaning of pneumoconiosis as defined by the Act. As noted above, "clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. A disease "arising out of coal mine employment" includes any chronic pulmonary disease or

respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201.

At his initial meeting with Claimant on October 14, 1999, Dr. Altmeyer noted that prior to 1969, Claimant worked for a company blowing an asbestos-containing compound onto walls and ceilings with an air gun. Claimant reportedly inhaled a significant amount of asbestos prior to his working in the mines. There is no mention of Claimant being exposed to asbestos while working in the coal mine. Throughout Dr. Altmeyer's notes, there is no mention of a diagnosis of pneumoconiosis. Moreover, Dr. Altmeyer did not comment whether Claimant's asbestosis was aggravated by the inhalation of coal mine dust. There is no evidence in Dr. Altmeyer's notes that Claimant's asbestosis arose out his coal mine employment. For these reasons, I find that Dr. Altmeyer's diagnosis of asbestosis is insufficient to establish pneumoconiosis as defined in the Act.[11]

I accord less weight to the opinion of Dr. Ranavaya on this issue. In his report, Dr. Ranavaya noted Claimant "reportedly" had radiographic evidence of pneumoconiosis and that therefore it was medically reasonable to conclude Claimant had CWP due to occupational exposure to coal mine dust. It is not clear to which radiographic evidence Dr. Ranavaya was referring in his report. Moreover, I found earlier that the great weight of the dually qualified chest x-ray readings were negative for pneumoconiosis. Because Dr. Ranavaya provided no other rationale for his opinion, I find his opinion on this issue is not well-reasoned, is not well-documented, and is less credible and persuasive than the opinions of Drs. Fino and Rosenberg, who concluded there was insufficient evidence to diagnose the presence of pneumoconiosis. Moreover, Dr. Ranavaya's opinion was equivocal in that he concluded Claimant's pneumoconiosis was "most likely" due to his occupational exposure to dust in the coal mine industry. For these reasons I accord the opinion of Dr. Ranavaya less weight.

I also accord less weight to the opinion of Dr. Lenkey on this issue. In his report, Dr. Lenkey noted a positive chest x-ray 1/0 and that the vent study showed borderline obstructive airways disease. He then diagnosed Claimant as having CWP due to coal mine dust exposure and that he was 100% impaired by pneumoconiosis. At his deposition, Dr. Lenkey explained that he based his diagnosis of CWP on years of coal mine employment, abnormal vent study, and abnormal chest x-ray. As noted above, I found that the great weight of dually qualified chest x-ray readings were negative for pneumoconiosis. As for the vent study, the results were borderline abnormal. Dr. Lenkey admitted at his deposition that Claimant had a significant smoking history that contributed up to 50% of his pulmonary impairment. He also agreed that obesity could have a mild effect on Claimant's oxygen tensions. Because of the equivocal nature of Dr. Lenkey's opinion regarding the cause of Claimant's pulmonary impairment between his

[11] Claimant testified at the hearing that a mechanic in the 1980s told him he was exposed to asbestos from the motors he was working on in the coal mines. However, this off-hand comment by a mechanic is insufficient evidence to establish Claimant's asbestosis arose out of his coal mine employment. Moreover, Claimant admitted that he had no independent knowledge that there was actually asbestos in the motors. Claimant also noted that arc shields and fire retardant blankets at the face were made of asbestos. Again, I find that Claimant's testimony in this regard is not convincing and is insufficient evidence to establish Claimant inhaled asbestos fibers while in the coal mine. The more likely explanation was the history Claimant provided to Dr. Altmeyer regarding his pre-1969 work with asbestos-containing insulation where he admittedly inhaled a significant amount of asbestos.

report and deposition, I accord his opinion less weight. Moreover, I find that the opinion of Dr. Lenkey is not as well-reasoned, well-documented, and persuasive as the opinions of Drs. Fino and Rosenberg. For these reasons, I accord the opinion of Dr. Lenkey less weight.

Conversely, I accord greater weight to the opinion of Dr. Fino on this issue. His opinion is well-reasoned and well-documented and is consistent with the objective evidence of record, Claimant's medical history, history of weight gain, and the results of the physical examination. Moreover, Dr. Fino's opinion was based on his own evaluation of Claimant as well as an extensive review of the medical evidence in the case, unlike Drs. Saludes and Lenkey, who each examined Claimant on one occasion and had only limited medical evidence on which to base their decisions. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984). Based on the foregoing, I accord greater weight to the opinion of Dr. Fino.

Likewise, I accord greater weight to the opinion of Dr. Rosenberg. He opined in his report that Claimant did not have pneumoconiosis but did have idiopathic pulmonary fibrosis (IPF) or asbestosis. However, prior to his deposition, Dr. Rosenberg was given additional medical evidence to review, including the medical reports of Drs. Fino, Ranavaya and Lenkey, as well as the pulmonary function study from 5-10-02. He also reviewed x-ray films from 1999 through 2002 and was not convinced that the changes seen were due to IPF or asbestosis. Based on his review of the additional information, Dr. Rosenberg reasonably concluded Claimant's major problem was massive obesity, hypoventilation, ventilation profusion, and mismatched obesity. Therefore, although Dr. Rosenberg's testimony was somewhat inconsistent with his initial report, the discrepancy in his opinion was explained at the deposition and was based on new information he obtained prior to the deposition. Therefore, overall, I find that the opinion of Dr. Rosenberg is well-reasoned and consistent with the objective diagnostic testing of record. For these reasons, I accord his opinion greater weight.

I find, based on the foregoing discussion, that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4).

Weighing all Evidence Together

Pursuant to the holding in *Compton*, I must weigh all of the evidence under § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I found previously that Claimant was unable to establish the existence of pneumoconiosis through x-ray evidence pursuant to § 718.202(a)(1). I found that there was no biopsy evidence in the record to establish the existence of pneumoconiosis pursuant to § 718.202(a)(2) and that the presumptions at § 718.202(a)(3) were inapplicable to the facts of the instant matter. In addition, I found that the conclusions of the better reasoned opinions did not establish the existence of pneumoconiosis pursuant to § 718.202(a)(4). Accordingly, weighing all of the foregoing evidence together, I find Claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a).

Cause of Pneumoconiosis Pursuant to § 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

Because Claimant was unable to establish the existence of pneumoconiosis, I find this element is moot. However, had Claimant established pneumoconiosis, I find that Claimant, with thirty years of coal mine employment, would have been entitled to the rebuttable presumption at § 718.203.

Evidence of Total Disability

A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner from performing his usual coal mine work or comparable employment. 20 C.F.R. § 718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Subsection 718.204(b)(2)(i) provides that total disability may be established by pulmonary function testing. There are four pulmonary function studies submitted as part of Claimant's claim for benefits. Of the four studies, none produced qualifying values. Therefore, I find that Claimant has failed to establish total disability under § 718.204(b)(2)(i).

Subsection 718.204(b)(2)(ii) provides that qualifying arterial blood gas testing may establish total disability. There are four arterial blood gas studies in the record. Three of the four studies are qualifying under the Act. Accordingly, I find that Claimant has established total disability pursuant to § 718.204(b)(2)(ii).

There is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure pursuant to § 718.204(b)(2)(iii).

Subsection 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that Claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment.

Four physicians have rendered an opinion in this matter relative to this issue. Dr. Lenkey opined Claimant was 100% impaired from performing the duties of his last coal mine employment. Dr. Ranavaya opined Claimant had a moderately severe disabling pulmonary insufficiency that would prevent him from performing his last coal mine employment. Dr. Rosenberg opined Claimant would be unable to perform his last coal mine employment due to

the degree of gas exchange abnormality. Dr. Fino opined Claimant would be unable to return to his last coal mine employment due to moderate hypoxemia and his significant history of coronary artery disease.

Based on the foregoing, it appears all of the physicians are in agreement that Claimant is totally disabled from a respiratory standpoint from returning to his last coal mine employment.

Accordingly, I find Claimant has established total disability within the meaning of § 718.204(b)(2)(iv). In weighing all of the foregoing, I find Claimant has established the existence of a totally disabling respiratory impairment pursuant to § 718.204(b).

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c)(1).

Pursuant to § 718.204(c)(1), a miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

Because Claimant failed to establish the existence of pneumoconiosis, this element is moot. Again, I rely on the credible and persuasive conclusions of Drs. Fino and Rosenberg, who opined that Claimant's pulmonary problems arose from his massive obesity and not any coal mine dust induced lung disease.

Conclusion

Because Claimant has failed to establish all elements of entitlement, I must conclude that he has not established entitlement to benefits under the Act.

Attorney's Fee

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of DONALD E. GILBERT for benefits under the Act is DENIED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.